On the Quest for the Humane Physician

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I would like to start by quoting from the book *Becoming a Doctor* by Melvin Konner, who describes his experience as an intern at one of the large Harvard-affiliated Boston hospitals.[1]

"Monday morning, on rounds, we all went into the patient's room and collected in a semicircle some distance from her bed. She lay completely constrained, weak and helpless, in a lower body cast and one arm in a shoulder cast, tubes in her nose and in her free arm. Her face was distressingly alert. The senior resident presented her to the group, and the attending physician asked him a few perfunctory questions. No one spoke to the patient, touched her, or even met her eyes during the 5 minutes we spent in her room. The senior resident was moving the group out when she began speaking. She looked around at the white coats in fear and confusion. In a thick, regional working-class accent, she asked, 'Can I have something for the pain?'

"The resident stopped, looked at her from where he stood about 4 feet from the bed and said, 'You bet.' This was the single exchange that occurred between this patient and a physician during the daily period at her bedside."

We all agree that this is appalling, yet does this vignette strike a respondent chord in anyone? Is it perhaps symbolic of what we fear has happened to us and to medicine?

None of us would ever choose to be involved in such a depressing encounter, and yet perhaps deep in our hearts we sense elements of truth, glimmers of guilt, and memories of our own behavior which we fear came very close to this nightmare.

The hallmarks of the humane physician may be considered to be integrity, respect, and compassion. The American Board of Internal Medicine has defined integrity as the personal commitment to be honest and trustworthy in evaluating and demonstrating one's own skills and abilities. Respect is our need to honor the choices and rights of those with whom we come in contact, most particularly, our patients. Compassion is the capacity and willingness to share in the pain and anguish of those who seek help from us, without at the same time permitting excessive emotional involvement.

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There are many different definitions but these will do. We must examine whether our humaneness as physicians, made up of these 3 characteristics, has diminished or disappeared. If it has, we must ask if this is a new or an old phenomenon, and whether it is derived from an inherent contradiction between science and technology on the one hand, and humanity and compassion on the other. Finally, we must consider what role medical education has played in creating and enhancing this lack of humanity. I will try to speculate on each of these, with particular emphasis on this last point.

The idealized, turn-of-the-century concept of the physician is best exemplified by the famous Norman Rockwell *Saturday Evening Post* cover showing a kindly, somewhat portly, older doctor standing by the bedside of a sick child with a hand cupped under his chin. The entire scene suggests compassion and empathy, and a wisdom derived from years of selfless service. Surely this is the image that we believe the public wishes of us, and in turn what we want to be. Has there been a downward spiral from this selfless, underpaid altruism to the greedy, egocentric, uncaring technician?

Looking back in history to 500 BC the great Greek philosopher Heraclitus said, "Doctors cut, burn and torture the sick, and then demand of them an undeserved fee for such services."[2] In the 17th century, LaBruyer remarked, "As long as men are liable to die and are desirous to live, a physician will be made fun of but will be well paid."[2] Benjamin Franklin said, "God heals, and the doctor takes the fee."[2] And Marcel Proust, one of the great hypochondriacs of the modern era stated, "Medicine being a compendium of the successive and contradictory mistakes of medical practitioners, when we summon the wisest of them to our aid, the chances are that we may be relying on a scientific truth, the error of which will be recognized in a few years time."[2]

Thus the perception that physicians lack humanity is not anything new; as an amateur sociologist I believe this reflects the fact that most people do not want to be dependent on others for their care and health, and that relying on a physician creates tension, anxiety and sometimes hostility.

Physicians' humanism probably has been perceived as deficient through the ages—but is it worse now? I submit that it is. A major cause is considered to be the sophisticated, successful system of medical education that has evolved in North America. I will paraphrase Edmund Pellegrino, "This criticism is especially poignant for medical educators, at whose door much of the responsibility for this lack of humaneness is laid. We are told

that we neglect the teaching of human values and the art of medicine, and that in our zeal for science we ignore liberal studies and that the patient care we provide in our teaching hospitals and clinics is itself dehumanizing."[2] As eloquent as Pellegrino is, what evidence does he have for this indictment?

Unfortunately, in order to obtain any firm ideas as to whether the process of creating a physician promotes dehumanization and diminishes intrinsic humanity, one needs to accept the scientific techniques of academic sociology, because that is where the data exist. For those of us trained in the requirements of hypothesis setting and testing that are necessary for medical science, conclusions derived from studies in the social sciences lack rigor. But these are all we have.

Let us start then with the premedical education of our potential physician. No less an authority than the Association of American Medical Colleges, in its 1984 report on the General Professional Education of the Physician, stated that many students "...embark upon premedical education with a narrow objective: To prepare for admission to professional school. The result too often is premature specialization and failure to obtain a broad rigorous education."[4] The logical extension of this is because premedical education in the past has been narrowly confined to scientific subjects such as organic chemistry, mathematics, physics and zoology, and has not included studies of music, art, literature, history and philosophy, that this imbalance ultimately creates a narrowly focused, unfeeling, inhumane physician. Such a hypothesis is superficially attractive but in no way proven. In fact, when the data supporting this is examined, there are none.

Although it may be true that those interested in the humanities turn out to be humane and sensitive physicians, it is likely that this is a self-selecting phenomenon; that is, those who happen to be sensitive and compassionate also happen to be concerned with the humanities.

We must recognize that there is a difference between the humanities and humanism. One of the consistent cliches in this area is the belief that the compassionate physician cannot be scientifically minded. As Seymour Glick has stated, "Focusing on the humanities as playing *the* pivotal role in compassion is misplaced and represents a misunderstanding of what humanities can and cannot accomplish. After all, the humanities, particularly the arts, are ethically neutral. They provide important aesthetic values but inherently embody few ethical values. For instance some of the world's most heinous crimes were perpetrated to the strains of Haydn and Mozart by individuals immersed in the works of Goethe and Heine."[5] It is true that the classic humanities teach reasoning, judgment and logic by exposing students to a variety of ideas. Accordingly, sensitivities are heightened, and the subtleties of life may be appreciated better. But exposure to the humanities by itself does not necessarily create a more humane physician. Glick says that we, as the educated elite of our society, project our own desires and prejudices when we stress the need for humanities as essential for physicians. Clearly we might prefer physicians who are cultured and capable of discussing the theater or the concert while palpating an abdomen, but the vast majority of patients probably are not concerned about what books their physician reads. Most patients want a competent and compassionate caregiver and not necessarily a cultured one. In my opinion, selecting a medical student with a broad background in the humanities should not imply that the exposure will *create* a humane physician; it is more likely that interest in the humanities and the potential for humaneness probably go together.

If it is not the premed process that starts this dehumanization, then clearly it must occur during medical school and residency. Konner's book and others, such as *The House of God*, amply describe the horrendous and shameful denigration of patients that occurs in our best medical centers, and they demonstrate the repeated exposure of impressionable medical students and residents to unfeeling, uncaring and inhumane professional behavior. Such desocialization starts with the students' first exposure to the cadaver and then proceeds as the students see how patients who are hopelessly ill and dying are dealt with. These critical incidents may have a profound effect on emotional maturation. The necessary distancing of physician from patient, which even the most compassionate and humane physician requires in order to function effectively, is often misinterpreted; for instance, the dispassionate recital of the symptoms and signs of a dying child at the beside must have a powerful impact on an impressionable student's mind. The message clearly must be, "This is how it is done, don't get too involved or you won't be able to function."

Agnes Rezler provided the best summary of attitude changes during medical school.[6] She confirms that the interpersonal attitudes of medical students change substantially from the first to the last year of medical school, and that special teaching programs really have very little impact in changing these attitudes. Furthermore, her data support the concept that the medical school environment fosters cynicism. Obviously, medical students, like all others, have personalities, motivations and fantasies, and they build psychological defenses. These mechanisms are necessary for their emotional survival during training. One of these defense mechanisms may be cynicism, defined as "behavior characterized by the conviction that human conduct is directed by self-interest or self-indulgence and that it is typified by detachment and toughness in interpersonal relations." Does this not accurately describe many of our colleagues, students and residents?

It all started with Abraham Flexner in the early part of this century, who surveyed the sorry state of our medical schools; he recommended and implemented a series of revolutionary changes so that medical education could become properly based as a scientific discipline. From these necessary changes, however, have evolved the following: First, an excessive concentration on accumulating and memorizing enormous numbers of facts; second, negligible contact with patients, sometimes not until the senior year; and third, a preoccupation with grades and competitive performance rather than on helping the patient.

Simultaneous with these changes occurred a series of breathtaking scientific breakthroughs with which we are all familiar: The discovery of antibiotics, the application of technology to diagnostic and surgical maneuvers providing heart-lung machines, sophisticated anesthesia and ventilators; the develop-

ment of imaging techniques which permit us to virtually dissect the human body with x-rays, contrast material, and radioisotopes; and finally the new era of molecular biology, which will lead to an even more astounding series of technological advances. Where does this leave the patient? Some would say he or she has become an object to be probed, dissected, analyzed, and assessed, often by specialists concerned with only one organ system. We forget that there is a psyche as well as a soma. We have no time to stand at the bedside with our hands under our chins being compassionate and wise. There is too much to do in the laboratory.

Contemporaneous with this tremendous increase in technological advance has been the intense competition among young people to become physicians, only recently abating. This competition was so extraordinary that collegiality disappeared, and it became each man or woman for her or himself. MCAT scores and competitive interviews were all that mattered. The same holds true for house-staff positions. Competition is the framework around which our premed students, medical students and residents work. It pervades our system of medical education. Intellectual elitism is our standard: It is not the most compassionate student or resident, it is the student who achieves the highest grades on his or her test scores selected by our honor society, Alpha Omega Alpha. Thus, the lessons learned by our students and residents are that the relationship with the patient has a low priority, that performance is measured best by grades, and that achievement is reflected by the prestige of the medical school, the residency program and the institution.

Coupled with this intense need to compete and achieve is the fact that residents change attitudes during their 3, 4 or 5 years of training. Data exist that indicate that house-officers consider themselves less idealistic about their role in medicine and its role in society, less patient, less tolerant, and less well-rounded as human beings.[7] Some confess to being more cynical, selfish, and materialistic than at the outset of their house-officer training. Many report heightened sensitivity to their own needs rather than to those of their patients, colleagues, and families. One survey indicated that one-third of residents felt that their self-image had worsened during their training, that their overall happiness was adversely affected by sleep deprivation and the resultant poor quality of life outside the hospital. Nearly all residents in this survey reported experiencing emotional distress during training.[7]

Rotbart and colleagues, who performed this interesting study, felt that cynicism, callousness and carelessness of physicians during residency and later in their careers were not inborn character flaws but were evolved self-protective mechanisms, and that the evolution of these defenses clearly begins during residency.

Rotbart further noted, "Energetic and altruistic young medical students are battered by a system that emphasizes economics over the emotional well-being of its trainees. The products are physicians who can do more damage to their patients in practice than they ever did during residency."[7]

If we accept the fact that the process of medical training inevitably leads to an increase in cynicim and a decrease in compassion, is there any way by which we can change this process? There are plenty of theories: For instance, emphasis on problem-based learning, in which students are taught both basic sciences and clinical medicine around a specific clinical problem, rather than in the traditional lecture format is thought to be a method by which humaneness is not compromised. But there are no data, none at all, that confirm this hypothesis even though many medical schools are making large-scale commitments to this educational method.

Unfortunately, I have a rather pessimistic view of the potential success of any attempts at changing this system. Not because medical educators, practicing physicians, medical students and residents are bad people and are therefore self-selected for lack of humaneness, but simply because of the impact of our current culture on values, goals and aspirations. The traditional Judeo-Christian view of human's role is that we exist to serve some higher purpose. Almost precisely antithetical to this is the pervasive philosophy of our time: Self-fulfillment, permissiveness and self-gratification.

Our society has been transformed from religious to secular. The revolution in child-rearing that has occurred over the past 50 years, in which happiness and self-expression are the preeminent objectives and where discipline and responsibility to others are submerged, may be more responsible for our lack of humaneness than any other factor. Glick states, "The crisis of humane medicine is the result of the failure of secular, democratic societies to inculcate moral and ethical values into their educational systems."[5] Furthermore, he points out that for a large proportion of Western society that is secular and not formally religious, a substitute for the ethical training derived from religion is an urgent societal need. It is likely that human motivations, goals, values and concerns are well-developed by the time a student enters medical school.

The premedical education of our students plays little if any role in initiating the dehumanization process. However, the complexities of our technological revolution and the necessities of compacting enormous amounts of information and learnable skills make dehumanization during medical training inevitable. To change this requires an enormous effort, because it means attempting to modify attitudes and values of all of those to whom our students are exposed.

But even more important, I feel, is that this process is as much or more a function of societal pressures, derived from our exaggerated emphasis on permissiveness and self-fulfillment as the ultimate goals in our lives. The pervasive effect of the media, and particularly television, inculcates an enormous concern for ourselves and our own need for self-gratification. An average of 7 hours of television viewing a day breeds passive, nonparticipating self-indulgence in which the entire external world is shut out. It becomes a narcissist's delight! And unfortunately, narcissism and compassion clearly are not compatible. In fact, liberalism, defined as a compassionate concern for those less fortune than we, has now become a label of shame and derision, so much so that our political candidates shun using it.

As Glick has pointed out, the belief in the uniqueness of humans and of service to a higher goal as the primary motives of

life may best be subsumed under the general rubric of a religious world outlook. But surely there are many humane physicians who are not religious and, contrariwise, there are many religious physicians whose humaneness may be questioned. The important point is that even those without formal religious allegiance may have distilled from their cultures and background important and positive ethical messages. As Glick says, "Whether these ethical distillates, uncoupled from their religious moorings, will be transmittable to subsequent generations remains questionable and probably will be one of the major tests by which our secular societies will be judged."[3]

My plea then is for a return to ethical values which, in the past, were best supported by a religious framework. I do not think it is necessary for us to attest to a formal religion in order to become more humane. I do think, however, that the quest for values and ethical standards is now, more than ever, a goal for which the humane physician must strive. Unless we do so, the deterioration of our culture will be reflected by a continuing lack of humanity in our care-givers.

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Autism in Hawaii

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autism expert to Honolulu. The first conference in 1991 featured Dr Gary Mesibov of Division TEACCH of the University of North Carolina at Chapel Hill, the 1992 speaker was Dr Douglas Bicklin of Syracuse University, and the 1993 conference presented Dr Temple Grandin, the best known person with autism in the U.S. She is a professor of animal husbandry and a national autism educator. To date, these annual conferences have trained more than 450 professionals and parents yearly.

Yet another contribution that will be of particular use to local physicians has been the availability of the newest screening questionnaire for autism, the Childhood Autism Test for Toddlers (CHAT). This straightforward 14-item questionnaire should be of great value for the initial screening of children as young as 18 months.[9] It is hoped this will help make possible the recognition of autistic symptoms at an age when active intervention can prevent the more serious sequelae of unrecognized autism. Copies are available from the Autism Project and can be requested by phone.

Of course these developments, helpful as they are, are only the beginnings of what is hoped to be accomplished. For example, the aforementioned survey identified the following key needs. 1) a structured special educational program geared to the child's developmental level of functioning, especially the unique communication problems of autism; 2) daily, intensive, individualized speech and language therapy; 3) auditory training; 4) technical assistance on behavioral management; 5) respite care; 6) appropriate residential care; 7) better education of medical students, residents and physicians; 8) creation of a statewide network of services to support children and families on all islands.

In addition to the humanistic and medical issues above, Hawaii is at an ideological and economic crossroads with regard to autism. If we continue as we have in the past, an increasing number of children with preventable handicaps will require expensive, lifelong institutionally based care. In addition to the cost to children and families, as teenagers without social and language skills and unable to express their needs, autism victims become unmanageable at home and in the community (unlike Down's syndrome for example), and hence will require institutional care. The expense of such care eventually bankrupts families and requires state funding, a cost in excess of $125,000 a year per adolescent, or a lifetime estimate of $6,250,000 per child. We already lack the institutional capacity to adequately address this issue. By delaying needed services until they are forced on us by the developmental pressures of adolescence, we are unable to avoid the expensive, institutional care. It is our hope that the presence of the Autism Project, combined with aroused community awareness, will allow us to adopt the prevention and cost-effective models present in several states, eg, North Carolina, New Jersey and California. These family and community-based coordinated service systems utilize both autism-specific and generic disability services in order to provide a full range of service options for persons with autism. Such a system not only can prevent the needless handicap in the higher functioning autistic child, but also can maintain the more severely impaired, low functioning autistic child in the community.

Hawaii is now moving in this direction, and it is hoped that physicians will support this improvement in care.

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